Sexually transmitted infections in Aboriginal and Torres Strait Islander and non-indigenous people (Australia)

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Introduction

Sexual and reproductive ill-health mostly affects women and adolescents. Women are disempowered in much of the developing world and adolescents, arguably, are disempowered everywhere. Sexual and reproductive health services are absent or of poor quality and underused in many countries because discussion of issues such as sexual intercourse and sexuality makes people feel uncomfortable. The increasing influence of conservative political, religious, and cultural forces around the world threatens to undermine progress made since 1994, and arguably provides the best example of the detrimental intrusion of politics into public health (Glasier et al 2006).

After pregnancy-related causes, sexually transmitted infections are the second most important cause of healthy life lost in women and some are passed to unborn and newborn babies. Sexually transmitted diseases are to a large extent infections of the young, mainly because their sexual relations are often unplanned, sometimes a result of pressure or force, and typically happen before they have the experience and skills to protect themselves. Although compiled data about sexually transmitted infection acquisition by age are sparse, US data show that young adults aged 15–24 years acquired 48% of all such infections, even though not all young adults this age are sexually active. Perversely, the young have the most to lose from acquiring sexually transmitted infections, since they will suffer the consequences the longest, and might not reach their full reproductive potential (Glasier et al 2006).

Chlamydia was the most frequently reported infection notified in Australia in 2008 with nearly 60,000 cases. In men, the rate nearly doubled between 2004 and 2008 from 125 for every 100,000 to 220 for every 100,000. In women, rates increased from 180 for every 100,000 to 325 for every 100,000 for the same period. Rates were greatest in the 20 to 24 and 25 to 29-year-old age groups. STIs also represent an increasing risk to the Queensland population. For instance, chlamydia has become the most commonly notifiable disease in Queensland with 15,009 notifications in 2008, which is a 73% increase since 2004. Notifications of gonorrhoea also increased in 2008 (36% over 2004 figures). Chlamydia and gonorrhoea disproportionately affect Australia’s Indigenous populations, young people and women (QH 2009).

'Figure 1: Age standardised rate of chlamydia by Aboriginal and Torres Strait Islander status and year'.
(The Kirby Institute 2011:14)

In Aboriginal and Torres Strait Islander peoples, chlamydia rates generally increased between 2004 and 2008, with the
exception of South Australia where they decreased. The graph above demonstrates reported chlamydia incidences compared with the non-Aboriginal population over the past few years. In some major cities in those areas, diagnosis rates were almost four times that of non-Aboriginal people, and in the remote regions of those areas, rates are nearly 13 times that of non-Aboriginal people (Australian Government 2011). Aboriginal and Torres Strait Islander women remain chronically disadvantaged due to the intersection of racial and gender discrimination. These women are particularly disadvantaged in their access to justice and legal services, especially with regards to situations of family violence and sexual assault. Aboriginal and Torres Strait Islander women also suffer from unequal access to accommodation, health, employment and education support services. Aboriginal and Torres Strait Islander women are also almost 20 times more likely to be incarcerated than non-Aboriginal and Torres Strait Islander women (Allard and MacDonald 2012).

**MDG 5 seeks to improve maternal health.** It includes two targets:

- to reduce by ¾ between 1990 and 2015 the maternal mortality ratio;
- to achieve universal access to reproductive health by 2015.

**2011 Update**

Of all the MDGs, Goal 5 is the most off track. Although some countries are achieving declines in maternal mortality ratios, overall worldwide progress was estimated by the World Health Organization to have only declined by 0.4% per year by 2005, falling far short of the 5.5% annual decline necessary to meet the 2015 goal (UN2011). Sexual and reproductive health is fundamental to the social and economic development of communities and nations, and a key component of an equitable society. We can bring sexual and reproductive health care and choice to those who need it most, which will be a vital contribution to making the world a fairer place (Glasier et al 2006).

**Case study: Chloe and Lola**

The following case study is divided into four parts addressing key areas for public health from: diagnosis, prevalence, protection and policy development, and explores patient narratives as well as service and policy perspectives. Each case study is underpinned by sign-posted reading material, audio reports and online pamphlets, which could be accessed via the web or printed for ease of access.

**Learning Outcomes**

The following learning outcomes (LOs) have been developed in relation to this case study and are also linked to the assessment criteria drawn from six areas of public health practice outlined in the national competency framework (Genat et al 2009) for Australian MPH (Masters in Public Health) graduates. The assessment criteria are also linked to some foundation principles, pedagogical strategies and institutional guidelines to support delivery of Indigenous public health competencies (PHERP 2008):

- understand the effects of cultural diversity within a specific health problem in Australia;
• outline risk factors associated with 14-19-year-olds who may be vulnerable to STIs with non-indigenous and indigenous female population groups;
• recognise the appropriate communication strategies required in developing culturally sensitive prevention programmes;
• build confidence in challenging current policy and highlighting priorities for effective health interventions in respect of equity and social justice particularly in relation to working with Indigenous people.

Case study stage one: narratives

A: Chloe from Adelaide

Chloe was scared. She had just had her 17th birthday but instead of feeling excited about her celebrations she was worried. She was just preparing for her last year exams before she goes to college to study statistics. Her boyfriend had totally distracted her by saying he had chlamydia. She didn’t know what to do, so she wrote to a girl’s magazine for advice. They told her:

“Chlamydia is a sexually transmitted disease. It is a cause of PID (pelvic inflammatory disease) and infertility (inability to get pregnant) in women. Now you are probably petrified! It is good of your boyfriend to mention that he has it and you need to have a course of antibiotics as soon as possible. Chlamydial infection in women is often asymptomatic (no symptoms) so it is important to have the antibiotics even if you feel fine and do not have a vaginal discharge. Similarly, if you don’t feel up to an internal examination at the doctor’s surgery, they should still give you a prescription. The long-term consequences are serious and the treatment very easy. You must also wonder where he got this from and if he could have acquired other infections? We often give treatment for gonorrhea at the same time and take the opportunity to discuss SAFE SEX. Condoms, condoms, condoms! Get some antibiotics!”

Chloe still found it difficult to understand how Chlamydia affects the body and then she watched this movie on the internet: http://www.health.qld.gov.au/istaysafe/movies/chlamydia-women.aspx

B: Lola from Cairns

Lola knew she was sick, she had been experiencing really bad pains in her lower abdomen for three weeks. She was 14 and scared. She had hidden her illness from her family during her recent initiation ceremony. She remembers how excited about the celebrations she had been, getting her face painted and her ears pierced and all her family with her. She had been ‘messing around’ with the local boys and wondered whether she should tell someone. Her dad would go crazy and her mum would cry. Lola hadn’t been to school for a few months now as her mum was pregnant with her fourth child and hadn’t been well. Lola thought about asking the family nurse who had been visiting her mum what to do, but she was afraid she would tell her mum who was very religious and would feel Lola had brought shame on the family. Her mum is very family orientated and holds a deep sense of belonging to her Torres Strait Islander roots.
**Case study stage one: activities**

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<th>Reflective questions</th>
<th>Areas of assessment (Genat et al 2009)</th>
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<tr>
<td>Ellis et al (2009) Let Them Know 2010 Royal Adelaide Hospital (2007) Better Health Channel (2012) Girl (2012)</td>
<td>Consider the family lives of these two girls – map out the likely causes and effects of their infections on the same paper using different colours for each case. What are the similarities and differences? What differences in culture and behaviour impact upon the health of these two girls?</td>
<td>Compare the different styles of information pamphlets – how useful do you think these are in these contexts? What impact do the social determinants of health have on these two cases?</td>
<td>Describe the determinants/causes of a significant population health problem. Analyse key indicators of social determinants of health for Aboriginal and Torres Strait Islander peoples.</td>
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**Case study stage two: prevalence**

The media highlights the concerns of increasing prevalence of Chlamydia:

Australia’s rates of HIV infection have remained stable for the last five years but gonorrhoea cases shot up 25% last year, while chlamydia rates have reached epidemic levels among young people, a new report shows. The annual 2011 HIV, viral hepatitis and sexually transmissible infections in Australia Annual Surveillance Report, produced by the University of NSW’s Kirby Institute for Infection and Immunity in Society, uses data collected from health departments, sexual health organisations, hospitals and research centres to develop a detailed picture of the state of the nation’s sexual health.

The 2011 report, which uses data collected in 2010, showed that more than 10,000 people were diagnosed with gonorrhoea in 2010, a jump of 25% since 2009. Chlamydia rates had soared 17% on 2009 levels.

“Chlamydia is increasing relentlessly. We have got a rampant epidemic, unfortunately, among young Australians aged between 15 and 30 years,” said UNSW Associate Professor David Wilson, Head of the Surveillance and Evaluation Programme for Public Health at the Kirby Institute.

**AUDIO:** [Sex disease epidemic](http://www.abc.net.au/news/2011-09-27/sex-disease-epidemic/2945918)
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<td>The Conversation Media Group (2011)  The Kirby Institute (2011) Australian Government (2010)</td>
<td>How would you describe a comprehensive response to STI [write out in full if not previously abbreviated] control? Please provide examples of how these responses may differ between Aboriginal and Torres Strait Islander and non-indigenous Australian women?</td>
<td>What are the differences in prevalence rates between Aboriginal and Torres Strait Islander and non-indigenous Australian women? Concerning the prevalence of STIs, what are Aboriginal and Torres Strait Islander girls aged 14 to 19 most at risk of?</td>
<td>Identify vulnerable individuals/groups and describe specific environmental health risks in a given community or population.</td>
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<td>Develop criteria to prioritise health problems for a specific population/community.</td>
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<td>Assess peer-reviewed and evidence-based information (including systematic reviews) relevant to a study in population health.</td>
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**Case study part three: prevention**

An annual snapshot of the nation’s sexual health has found an alarming jump in some sexually transmitted infections. New cases of gonorrhoea rose 25% in 2010. Epidemic levels of chlamydia among generation X and Y are continuing unabated. Researchers and health advocates say the figures are evidence of a need for a major funding increase to awareness and intervention programmes, particularly in indigenous communities. Professor says increased testing has not kept pace with a jump in diagnosis over the past year, and is calling for greater funding for awareness programs designed to curb infection.

"Prevention programmes are starting. There have been some piloted programmes in place. These are good measures but not enough," he said. "We need to have some targeted, good prevention programmes to reduce these epidemics that are clearly on the rise."

Researchers say the study shows disproportionate rates of gonorrhoea and chlamydia among Aboriginal and Torres Strait Islander people, particularly in remote and very remote communities. The survey showed 36% of all gonorrhoea cases in 2010 and 9% of all chlamydia cases were among Aboriginal and Torres Strait Islander people.

James Ward, Head of UNSW’s Aboriginal and Torres Strait Islander Health Programme, says a large pool of existing infection, youth demographics, and mobility are driving the STI epidemic.

"I think we need to have some systematic indicators for primary health care services delivering to Aboriginal and Torres Strait Islander people," he said. "Just last year we had 75,000 cases diagnosed in Australia. That’s more cases than of any other medical condition in Australia."
Although more people are getting tested for sexually transmitted infections, the overall rise in chlamydia rates was so great it could not be explained by more widespread testing, he said.

“It points to the fact that unprotected sex is still relatively common among young people. We need to come up with some innovative preventive strategies,” he said. “We need something coordinated that will reach the populations at risk because what we are doing to date isn’t working.”

### Case study stage three: activities

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<td></td>
<td>What are the key prevention indicators for chlamydia?</td>
<td>Describe key stakeholders within the Torres Strait Islander population in association with this health problem.</td>
<td>Develop a health promotion plan, specifying target groups and including specific goals, objectives, strategies, broad budgetary implications and related evaluation criteria based on the best available evidence.</td>
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<td>How could Cultural Communication Clues support an effective chlamydia prevention programme?</td>
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### Case study part four: policy

The potential for future ill-health resulting from undiagnosed chlamydia is what provides the rationale for funding chlamydia prevention programmes (Guy et al 2011). Chlamydia is costing health care systems billions of dollars to treat not only the acute infections, but also the complications they cause. In particular, the costs of treating subfertility due to chlamydia are high as tubal surgery and in vitro fertilization are expensive. A combination of approaches is likely to be required to have a significant effect on the burden of disease associated with genital chlamydia infection and to reduce population prevalence (Shaw et al 2011). By necessity, policies aimed at reducing the burden of disease associated with chlamydia infection need to include access to, and quality of, healthcare services equipped to identify and manage people with or at risk of infection.
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<td>NACCHO 2007&lt;br&gt;Australian Government (2010)&lt;br&gt;Queensland Health 2009&lt;br&gt;AHRC 2012&lt;br&gt;Close the Gap 2012&lt;br&gt;Shaw et al (2011)</td>
<td>Consider the disparities in health status between Aboriginal and Torres Strait Islander and non-indigenous population groups in Australia as identified within the case study so far – what are the main factors that contribute to these differences?&lt;br&gt;What barriers exist in implementing chlamydia prevention strategies?&lt;br&gt;What elements of primary, secondary and tertiary prevention and treatment strategies will positively impact upon Torres Strait Islander communities?</td>
<td>How does the Ottawa Charter for Health Promotion provide the framework for effective STI health promotion action?&lt;br&gt;How is the Closing the Gap campaign helping to address MDGs 5?&lt;br&gt;Consider the criteria for prioritising health interventions balancing competing needs, equity and social justice for Aboriginal and Torres Strait Islander and non-indigenous population groups to reduce the incidence of chalmydia.</td>
<td>Explain how legal frameworks, organisational structures and service delivery systems influence disease prevention and control.&lt;br&gt;Describe international/national/state/regional priority health problems relevant to specific populations/communities.</td>
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References


• Purdie N and Buckley S. (2010) An investigation into the attendance and retention of Aboriginal and Torres Strait Islander students: Research and theory about what works A literature review [online]. Closing the Gap Clearinghouse. Available from: http://research.acer.edu.au/cgi/viewcontent.cgi?article=1120&context=research_conference&sei-redir=1&referer=http%3A%2F%2Fwww.google.co.uk%2Furl%3Fsa%3Df%26rl%3D6%26ct%3Dl%26url%3Dhttp%253A%252F%252Fwww.letthemknow.org.au%252Fdoc%252Ffactsheets%252FLTK_Chlamydia_FS.pdf%26ei%3DxPsEUN6aMeit0QX3gsy3Bw%26usg%3DAFQjCNFCO3c9jG8MPLGgeoyo9sB8zHPM7Q#search=%22school%20attendance%20retention%20non-indigenous%20australian%20youth%22 [Date accessed].


- The Kirby Institute. (2011) HIV, viral hepatitis and sexually transmissible infections in Australia Annual Surveillance Report 2011. The Kirby Institute, the University of New South Wales, Sydney, NSW.

